



The Health of New Hampshire's Community Hospital System

A Financial Analysis

Alice Peck Day Memorial Hospital



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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS ¹	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

¹ Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses) ²
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

² (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire*.

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with \$100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

ALICE PECK DAY MEMORIAL HOSPITAL, LEBANON, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS

Alice Peck Day Memorial Hospital is a small hospital serving residents of Grafton County. Facilities include 32 acute-care and 50 nursing home beds³. As of 1997, private insurers followed by Medicare represented the largest percentage of payers for inpatient discharges (65% and 24%, respectively)⁴.

In fiscal year 1995, Alice Peck Day Health Systems Corporation became the parent company of the hospital. Affiliated organizations include Alice Peck Day Physician Hospital Organization and Alice Peck Day Lifecare Center (d/b/a Harvest Hill), a nonprofit assisted living facility.

Summary of Financial Analysis 1993-98

The hospital's financial performance during this period was not as favorable as other New Hampshire hospitals, as illustrated by low and erratic profitability and declining solvency and liquidity indicators. Despite a period of stable positive margins, profitability fluctuated and was low relative to other hospitals in the state, requiring the hospital to increase its level of financial risk and decrease liquid resources to meet plant and equipment needs. 1998 operating losses raise a number of red flags, particularly with regard to the hospital's ability to service its debt.

Cash Flow Analysis 1993-98

The six-year cash flow analysis illustrates a pattern of cash sources and uses oriented primarily toward improving property plant, and equipment, mostly using internally generated cash sources. Forty-four percent was generated by depreciation, while only 18% was generated from net income as a result of relatively thin operating profitability. To generate additional capital, the hospital liquidated marketable securities (19% of total cash sources) at a time when other New Hampshire hospitals were able to build large strategic cash balances. Selling these assets also removed investment income that could have enhanced the bottom line. The hospital augmented internally generated funds with additional long-term borrowing, which produced 17% of the total cash over the period, and increased the hospital's level of financial risk, although still within normal ranges.

The hospital's largest use of cash was investment in property, plant and equipment (79% of total cash uses). This level of investment was twice the level of depreciation expense over the period, which resulted in an average age of plant of 8.6 years in 1998.

Affiliate transactions absorbed 6% of the hospital's total cash.

Ratio Analysis 1993-98⁵

Profitability

Total margins are erratic and low relative to the state median, while operations fluctuated close to break even. After 1994, a stable to decreasing markup combined with an increase in revenue deductions for payer discounts (deductible) contributed to the unfavorable trend for the operating margin, with a sharp jump in 1998, contributing to that year's operating losses.

Nonoperating revenues were not broken out from operating income after 1993. This reporting practice may mask additional operating losses than we were able to determine. Nonoperating losses (but not

³ 1998 American Hospital Association Guide.

⁴ 1997 data from the State of New Hampshire Department of Health and Human Services.

⁵ NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

revenues) were broken out, making the total margin appear slightly lower than the operating margin in these years.

Footnotes to the financial statements provided information on realized gains on the sale of investments from 1995 to 1998. We did not use this information to break out these nonoperating revenues because the footnotes did not explicitly state that this income was unrestricted. As an estimate, however, this investment income information reveals the growing importance of realized gains to the bottom line after 1995.

Liquidity

The hospital's liquidity deteriorated during this period. Though the current ratio dropped by half in 1998, this measure showed that the hospital could meet its current obligations. Prior to 1998, this measure was strong, though this did not necessarily indicate strong liquidity since it was driven by growth in accounts receivable (not a highly liquid asset), which increased by 1.7 fold between 1993 and 1998. This unfavorable trend is illustrated by an increasing days in accounts receivable, from 56 to 69 days, which is high relative to the state median. This growth was partially funded by slowed payments to vendors as illustrated by the increase in the average pay period from 41 to 57 days, another unfavorable trend.

The decreasing trend in the current ratio also reflected the decreasing cash balances. The hospital liquidated most of its discretionary cash reserves in 1994, as reflected in the days cash on hand measures with short-term and all sources; total days cash on hand decreased to 40 days by 1998.

Capital Structure

The hospital has assumed a fair amount of debt, which is captured by a low and decreasing equity financing ratio (equity/total unrestricted assets). Approximately two-thirds of the hospital's total assets were financed by debt. The decrease in this ratio from 1995 to 1998 is due to a combination of equity transfers to the parent between 1995 and 1997 and issuance of new debt in 1996 (\$2.2M). Though the parent transferred equity to the hospital in 1998, solvency still declined due to operating losses and an increase in short-term debt sources. An increase in short-term debt sources is a red flag given the hospital's large investment in long-term assets and its deteriorating liquidity position.

Debt coverage ratios fluctuate due to erratic profitability. The precipitous drop in cash flow to total debt to only 6% in 1998 is a red flag, as is the 50% drop in debt service coverage, which reveals a marked decrease in the hospital's ability to cover its debt principal and interest payments. The 1998 level of debt service coverage is at the lowest end of the normal range; further deterioration may trigger active concerns by creditors.

Note: The 1995 financial statements indicate that the hospital plans to serve as the guarantor on a \$6.6 M bond issuance by its affiliate, Alice Peck Day Lifecare Center. There is no further mention of the issuance after 1995. However, such a guarantee further increases the financial risk of this small hospital.

Charity Care

Charges forgone due to charity care represented between 0.4 and 1.3% of gross patient service revenues. Charity care measured as charges forgone does not consistently meet the estimated value of the hospital's tax exemption until 100% of bad debt is added. After 1995, this benchmark is met with the inclusion of 50% bad debt.

In addition to charges forgone, the hospital consistently reported costs incurred exceeding payment for Medicaid patients as charity care. (Medicaid costs exceeding payments are not allowable under New Hampshire's community benefit statute.) The cumulative amount for these services from 1993 to 1998

was \$927K. The hospital also reported community services in the form of health evaluation and screening programs at community/work sites, flu shot clinics, health education and fitness programs at an estimated cumulative cost of \$550K, though it is unclear whether the hospital received payments for these services. With the inclusion of these costs, quantified community benefits far exceeded the estimated tax value.

The hospital also listed over 20 service organizations for which it provided materials or its employees volunteered time.

In addition to charity care, the hospital has a trauma center¹, which may be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 – 1999

The largest portion of Alice Peck Day's cash has been generated from non-cash expenses (46.3%). The next largest portions come from surplus and the sale of marketable securities at 20.3% and 6.1%, respectively. Long-term debt represents 10.8% of the generation of cash, and 6.6% had been transferred from restricted to unrestricted funds.

The vast majority of cash (72.5%) has been used to invest in property, plant and equipment (PP&E). Purchases since 1996 are reflected in the decrease in the average age of plant from 8.76 years in 1997 to 8.1 years in 1999. 9.6% of the cash has been transferred to the affiliate. Increases to net working capital and other non-current assets represent roughly 7.7% each. 2.5% of cash was used to increase cash reserves.

1999 Ratio Analysis

Profitability

After the 2% deficit in the total and operating margins in 1998, the hospital has returned to profit in 1999. An operating margin of 3% in 1999 was due to a 10% increase in operating revenue and a 4% increase in operating expenses. Non-operating gains contributed 25% of this profitability. Overall, the hospital is showing a decent profit for this industry. The 3% operating margin is at the 75 percentile for New Hampshire hospitals and above the median in regards to the national average in 1997.

Liquidity

The hospital can meet its short term-liabilities 1.67 times over, as demonstrated by the current ratio, with and without board designated funds. Although this is slightly below the national average, it is better than 20-30% of the hospitals in the state. The hospital improved collection in 1999, reflected in days in accounts receivable of 66.71, down from 69.95 in 1998. This is slightly higher than the national average, and in roughly the 50th percentile in the state. The hospital has demonstrated a quicker payment period of 49.09 days, which is among the highest in the state of New Hampshire. The hospital also demonstrates a days cash on hand of roughly 39 days, with and without board designated funds, continuing a pattern of decline beginning in 1995 (when the days cash on hand was 106). Largely due to the drawing down of cash resources, the hospital's liquidity is decreasing, but still within a healthy range in terms of key ratios.

Capital Structure

The hospital is more leveraged than the average hospital in the state with an equity financing ratio of 0.45, a value that is well below the national average and easily among the lowest in the state. However, debt service coverage was a reasonably healthy 2.58 times in 1999, up from 1.43 in 1998.

Charity Care and Community Benefits

In 1999, charity care reported as charges forgone represented 0.46% of gross patient service revenue (GPSR). This is down from last year's 1.18%. The hospital wrote off 2.58% of the GPSR as bad debt. The hospital provides additional community benefits in the form of screening programs, flu shot clinics, health education, and fitness programs, which totaled \$124K in spending. The hospital also donates its resources and staff to several community-wide programs including the American Red Cross, Savvy Seniors, United Way of Upper Valley, and Alcoholics Anonymous.

Summary

1999 represented an improvement in profitability that, in turn, boosts their solvency ratios. Liquidity remains below the New Hampshire state averages. This represents a relatively stable financial situation for a small hospital.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health